WEST VIRGINIA DIVISION OF JUVENILE SERVICES	POLICY NUMBER: 306.00	PAGES: 10
CHAPTER: Institutional Operations	**REFERENCE AND RELATED STANDARDS:** WV Constitution, Article 3, Section 5; U.S. Constitution 8th Amendment. WV Code Chapter §§ 49-2-903 and 49-2-906; ACA-3-JDF 3A-16 thru 18, 3A-27 and 3A-30; PbS Standards – Safety 1-2; Order 2	
SUBJECT: Use of Physical Force and Restraints		
DATE: July 1, 2017		

PURPOSE

This policy establishes guidelines for the Division of Juvenile Services regarding use of physical force and mechanical restraints by Division of Juvenile Services personnel.

CANCELLATION

This policy has been revised and supersedes Policy 306.00 dated July 1, 2016.

APPLICABILITY

This Policy applies to all Division of Juvenile Services' facilities and/or offices.

DEFINITIONS

1. **Direct Supervision**: Physical presence by staff in the same area and within reasonable hearing distance of the resident where he/she is able to respond immediately.

2. **Disturbance Control Training**: Training offered to DJS employees that better prepare them to deal with facility disturbances that range from single living areas to large multipurpose units or areas.

3. **Emergency Restraint Chair®**: A chair that is equipped with a series of soft restraints that are designed to restrict or prevent a person's ability to move freely. The primary function of the restraint chair is to prevent a resident from injuring themselves or others due to out of control behavior.

4. **Empty Hands Tactics**: Self-defense, submission and come-along controls designed to gain control of the resident and overcome the aggression.

5. **Force Continuum**: Progression of force used by staff based on the level of resident resistance encountered.

6. **Out-of-Control Behavior**: Residents who are not amenable to reasonable direction and control which compromises the safety and security of the facility or staff and other residents.

7. **Physical Force**: Agency authorized and trained holds by staff to subdue an otherwise uncontrollable youth in order to prevent the resident from injuring him or herself or others. Does not include escort techniques and routine contact with compliant residents.

8. **Resistive Behavior**: Behavior which is passive in nature but is not aggressive nor poses any danger to the resident, other residents or staff. This behavior disrupts the day-to-day operation of the facility.

9. **Restraints**: Handcuffs or wristlets, chains or anklets, soft leather restraints, the Emergency Restraint Chair®, The Wrap™, or any other approved or authorized device used to limit movement of a resident's body to prevent significant harm to self or others, or prevent escape.

10. **Safety Helmet:** A protective helmet used to protect the head and face of a juvenile that has shown behavior of self-harm. (i.e.; hitting head on wall and/or floor surface, etc.)

11. **Spit Shield:** A clear shield or net which prevents the resident from spitting on other persons.

12. **The Wrap™:** A restraint system made up of flexible material and Velcro straps that prevents kicking and restrains the resident in an upright seated position or while lying on their side, and does not hinder the resident's ability to breathe.

PROCEDURES

1. **Force Continuum**

   a. Levels of Resistance: Force used by resident against staff who are affecting control or in the lawful performance of assigned duties, as outlined in Attachment #1, Resident Resistance, Staff Control Continuum.

      i. Psychological Intimidation – Non-verbal actions, often called, "body language" that influences decision-making on how to approach a resident or what level of control to use if a resident starts to resist. Such actions may include clenching of fists, widening of stance, or blank expression that indicates resident's emotional state.
      ii. Verbal Non-compliance – Any verbal response indicating the juvenile's unwillingness to obey commands of direction. Verbal Non-Compliance may come in the form of a simple "NO" or a threat directed at the officer. A resident's dialogue that offers the threat of physical resistance to commands is not normally considered resistance until the resident physically resists control.
      iii. Passive Resistance – Passive resistance is the lowest form of physical resistance. The resident resists control through passive, physical actions. At this level, the resident never makes any overt attempts to overcome physical compliance generated by staff. Passive resistance is usually in the form of relaxed or "dead weight" posture intended to make staff lift or pull the resident to establish control.

iv. Defensive Resistance – The resident is physically resisting any attempt to control the resident by using defensive, physical actions. With this level of resistance the resident attempts to push or pull away in a manner that does not allow staff to establish control and there has been no attempt to harm staff by the resident.

v. Active Aggression – Active aggression is when a resident attacks staff to overcome attempts to compliance techniques. The attack is a physical assault on staff in which the resident strikes, attempts to strike, or uses techniques in a manner that may result in injury to the resident, the staff, or others.

b. Levels of Control: Control is defined as the techniques used by staff to restrain residents' resistive behavior. The levels of control are:

i. Staff Presence: Involves the presence of additional staff members. This may include uniformed and non-uniformed staff. The presence of staff will bring with it the symbol of order and control and may resolve the situation.

ii. Verbal Direction: Commands or direction that will be clear and precise. The resident should not be confused by the directions given. Interpersonal skills can be the most effective way to deal with any situation. If conditions permit, a staff person who is unable to resolve a situation involving a resident who is displaying passive resistance is to allow the resident to experience a cool down period so he/she can consider the consequences of his or her actions.

iii. Soft Empty Hand Control Techniques: These techniques are designed to deal with passive resistance and in most cases defensive resistance. These techniques include joint locks, strength techniques, pressure points, and distraction techniques. Soft empty hand control techniques are techniques that cause little or no injury, and are designed to deal with low levels of resistance.

iv. Hard Empty Hand Control Techniques: These are techniques that are designed to control active aggression and may be used during these types of situations. These techniques include defensive counter strikes, such as a knee strike, straight punch, radial strike, median strike, angle kick, palm heel strike.

NOTE: Hard Empty Hand Control Techniques are ONLY to be used when a staff person is being physically assaulted, or witnessing a third party being physically assaulted by a resident.
For example, when a resident:

1) **is choking another resident or staff,**
2) **has grabbed a staff member or another resident and refuses to release, and is an immediate threat, or**
3) **is attempting to gain access to a weapon and will not release it.**

v. Restraints: Restraint equipment that is intended only as a control measure and only when all other actions appropriate to the situation have been ruled out. It is not intended for, and is prohibited to be used as a means of discipline or punishment.

2. **Administration of physical force**:

a. Examples of out-of-control behavior and conditions for use of physical force:

i. Justifiable self-defense,
ii. The resident is in the process of assaulting another person,
iii. The resident is in the process of willfully destroying state property,
iv. The resident is attempting suicide,
v. The resident is inflicting wounds upon him or her self,
vi. Prevention of an escape, or
vii. Disruption of facility safety and security caused by refusal of residents to follow instructions.

b. Limitations on the use of physical force:

i. The amount of physical force applied shall not exceed the force necessary to gain control of the resident and ensure the safety of the resident, staff or others, prevent serious damage to the facility, and ensure facility security and order.
ii. Use of physical force must be approved and supervised by the Shift Supervisor unless the resident's behavior constitutes an immediate threat to him or herself, other residents, staff, or other person or property and order of the facility.

3. **Restraints**:

a. Mechanical Restraints

i. Limitations on the use of Mechanical Restraints

1) Restraints may be used when a resident is out-of-control and other efforts as set forth in Section 1. a. of this policy have been exhausted.
2) Restraints may be used to maintain control of residents as prevention against active aggression, serious self-injury, and significant property damage.
3) As a precaution against escape or assault during transport in accordance with Policy 314.00 – Transportation of Residents.
4) The application of restraints will be videotaped. If circumstances do not allow, recording should begin as soon as possible and shall continue until the resident is released from restraints.
5) The resident shall always be under direct supervision by staff while in mechanical restraints.
6) Mechanical restraints are to be removed as soon as the resident is calm and cooperative.
7) Restraints will not be applied for more than two (2) hours at a time except during transports outside the facility that may take longer than two (2) hours to complete. The Facility Superintendent/Director or designee may authorize restraints to remain on the resident longer than two (2) hours if he/she deems it necessary to maintain control of the resident.

8) When moving residents within the facility who are deemed an imminent physical threat and this restriction is outlined as a condition in their Behavior Modification Plan. The Division Director is to be notified in all cases where this restriction is part of a resident's Behavior Modification Plan.

9) Pregnant residents:

a) Pregnant residents in their first trimester of pregnancy may only be handcuffed with their wrists in front of their body.
b) Restraints of any type may not be used on pregnant residents who have reached their second trimester of pregnancy through the end of the pregnancy, unless the resident poses a threat of escape, or to the safety of herself, other residents, staff, the public or the unborn child. Use of restraints must be based upon her classification, discipline history or other factors deemed relevant by the Division Director or his/her designee.

1. Staff will collaborate with medical staff to determine whether the use of restraints is necessary.
2. Any use of restraints on a pregnant resident must be documented, with the rationale for use of said restraint, including length of time or total duration of restraint use, type of restraint used and in what manner, etc.

c) No restraints of any type will be used on any pregnant resident who is in labor, during delivery, or in recovery immediately after delivery.

ii. Security and accountability of mechanical restraints:

1) No restraints are to be present on the grounds of a facility except those owned and issued by the Division or those in the possession of law enforcement officers who are visiting the facility on official business.
2) Staff will sign out restraints when they are utilized except when emergency conditions will not allow.
3) The shift supervisor will conduct an inventory of restraint equipment at the beginning of each shift. The information will be documented in the shift log in OIS.
4) Restraints must be secured in an area accessible to staff and not accessible to residents.

b. The use of The Wrap™ and Emergency Restraint Chair® (ERC®)

i. The following apply to both types of specialized restraints:

1) A resident is engaging in continuous out of control behavior which would cause serious bodily injury to self or others and would justify the use of restraints to control the behavior.

2) All other lesser forms of interventions have been unsuccessful as outlined in this policy.
3) The shift supervisor witnesses the behavior.
4) All activity surrounding the use of The Wrap™ and ERC® must be videotaped and documented. Additionally, the authorizing shift supervisor must complete The Wrap™ checklist, in OIS. The videotape will be uploaded into the appropriate shared document.
5) Medical staff is available to evaluate the resident for proper blood circulation, respiration and vital signs following application of the Wrap™ or ERC®. This will be done every 15 minutes or until the resident is removed from the restraint. Pursuant to subsection 2.b.i., of this policy, The Wrap™ and ERC® shall not be applied longer than necessary to regain control of the resident and the resident remains calm and cooperative.
6) The spit shield and safety helmet will be used on a resident on an as-needed basis. Such determination will be made by the shift supervisor.

ii. For the use of The Wrap™:

1) The behavior has been verbally reported to the Facility Superintendent/Director and the use of The Wrap™ has been approved by the shift supervisor.
2) Staff trained and properly certified in the application of The Wrap™ are available to apply the device and the resident shall remain under direct supervision by a Wrap™ trained employee.
3) The Wrap™ will not be applied to residents during transports.

iii. For the use of the ERC®:

1) The behavior has been reported to the Facility Superintendent/Director, who will then determine if the ERC® is warranted. If so, the Division Director or designee must be notified to obtain approval for the use of the ERC® (Attachment #2). A Behavior Management Plan will be developed by the treatment team.

    a) If the resident's behavior remains out of control for more than two (2) hours, authorization from the Facility Superintendent/Director must be obtained to continue the use of the ERC®.
    b) The Division Director must be notified each time the ERC® is re-authorized for continued use.

2) For purposes of self-injurious behavior, the behavior will be reported to the Division's mental health vendor, who will determine if the ERC® is warranted. If so, facility staff must notify the Facility Superintendent/Director, who will then notify the Division Director or designee to obtain approval.

    a) After application of the ERC®, the Division's mental health provider will determine the next appropriate steps for the resident.

b) A Behavior Modification Plan is developed and reviewed by mental health provider. This plan can only be changed by the mental health provider.

3) Staff trained and properly certified in the application of the ERC® are available to apply the device and the resident shall remain under direct supervision by a ERC® trained employee.

4. **Disturbance Control Training (DCT):** Utilized when dealing with major disturbances in a DJS residential facility.

a. Shift Supervisor is responsible for:

i. Securing the area and initiating verbal de-escalation with residents involved. This will continue for the duration of the disturbance.

ii. Providing a staff briefing prior to executing the response including but not limited to:

1) Name of team members and their assignments,
2) Brief description of disturbance, attempts to de-escalate, residents involved, and
3) Threat level of residents involved to include any weapons they may have.

iii. Ensuring that the disturbance is videotaped in its entirety.

iv. Notifying appropriate personnel, to include:

1) Facility Superintendent/Director,
2) Administrative Duty Officer (ADO),
3) Medical staff,
4) State Police based on the facility Operational Procedure and with approval from the Division Director or designee, and
5) Local Emergency Medical Services (EMS) as needed.

v. Ensuring the safety of residents and staff at all times.

vi. Conducting a debriefing with staff after the situation has been resolved.

b. Criteria for initiating a tactical response:

i. Resident offenses:

1) Residents, staff, or others are being harmed,
2) Significant damage is being done to State property, and
3) Escapes are being attempted.

ii. Required actions of staff (unless dire conditions exist):

1) Attempts to de-escalate and compel compliance have been exhausted, and
2) The Shift Supervisor has made a final attempt to verbally persuade the resident to comply.

5. **Room Entry**: Utilized during times when staff would be required to enter and remove a resident from any area.

a. Prior to any room entry, the Shift Supervisor shall gather and document via videotape all information regarding the situation. Required information includes:

i. Resident's name,
ii. Location,
iii. Resident's history,
iv. Events leading to or causing the immediate situation,
v. Steps taken to de-escalate the situation,
vi. Layout of the room, door opening, keyed or electronic door,
vii. Environmental conditions such as wet floors, resident oiled down, obstructions,
viii. Resident threat level including potential weapons, seriousness of threat, capacity of resident to carry-out threats, and
ix. The current medical condition of the resident.

b. Room Entry criteria:

i. Resident offenses:

1) Residents, staff, or others are being harmed,
2) Significant damage is being done to State property,
3) Escapes are being attempted, or
4) Resident refuses to move from an unauthorized location.

ii. Required actions of staff (unless dire conditions exist):

1) Attempts to de-escalate and compel compliance have been exhausted,
2) The resident has been given ample opportunity to consider his/her actions and related consequences, and
3) The Shift Supervisor has made a final attempt to verbally persuade the resident to comply.

6. **Videotaping planned restraints or disturbance control techniques (All incidents of planned restraints MUST be videotaped)**:

a. The Shift Supervisor shall record his or her name and rank as well as the current time and date on the Shift Commander Videotape Briefing form (Attachment #3) along with the names, ranks, relative positions and responsibilities (when appropriate) of others involved in the restraint.

b. Full name and number of all residents shall be recorded along with information about possible weapons as well as the resident's actions and attitude.

c. One last verbal warning for residents to comply should be recorded prior to any action.

d. If the resident refuses to comply in a room entry, the door will be ordered opened and the team shall implement the restraint.

e. Videotaping will continue as long as the resident is in restraints.

f. At any point the resident becomes unclothed the camera angle will be diverted but the camera will continue recording so the audio will not be interrupted.

g. Injuries to all residents or staff shall be videotaped following the event and the Shift Supervisor shall state the time and date of the conclusion of the videotape (Attachment #4, Room Entry Debriefing).

h. Once all residents are restrained, medical staff shall evaluate them for proper blood circulation, respiration and vital signs. This will be done every 15 minutes or until residents are removed from the restraints. (Ref: Policy 414.00 attachment #1 - Observation Sheet.)

7. **Follow-Up Procedures**

a. Medical Examinations: Residents and injured staff members involved in a restraint or physical force incidents will receive medical assistance from the facility's medical unit as soon as possible after the incident. Any injury that occurred will be documented in OIS and photos will be taken of the injury. If a resident initially refuses to been seen by Medical, Medical will follow up within an hour of resident's refusal. If resident continues to refuse medical attention, Medical will document in OIS any observed injuries and will follow-up when the resident is compliant.

b. Once a resident has been removed from restraints, medical staff will again follow up with the resident no more than 24 hours later to determine if the resident has injuries that was were not disclosed when the restraints were initially removed. Medical staff will document in OIS and ensure additional photos will be taken, if necessary. Medical staff will enter a new incident report and will ensure it is connected to the initial incident report.

c. Reporting: After every incident in which a staff member has used physical force and/or mechanical restraints, supervisors will ensure the employee(s) who are involved/witnessed the incident will immediately (before close of duty) complete their incident details from the main report in OIS. The supervisor will also confirm that any handheld video taken is adequate to provide information needed before the end of the shift in which the use of force occurred.

d. All use of force video, to include hand-held and body-cam video, will be uploaded to the Division's shared drive and the Use of Force Review Report initiated in OIS within three (3) business days of the incident occurring. The use of force video will include at least ten (10) minutes of video prior to the initial incident. (If video is not available, the reason must be documented on the review report.) The Use of Force Review Report will be completed by the required facility staff within five (5) business days after the use of force video has been uploaded. If the review reveals that excessive force may have been used the Division Director, Deputy Director or designee will be notified immediately.

e. The Investigative Unit will review the use of force video and complete the Use of Force Review Report within ten (10) business days of the facility's completion of their portion of the report.

f. Investigation and Reporting:

   i. The Division Director or Deputy Director or designee determines when an investigation is warranted.
   ii. The Division Director or Deputy Director or designee as well as the Facility Superintendent/Director or designee will immediately follow the procedures described in Policy 335.00 – Facility Child Abuse and Neglect regarding the reporting of institutional child abuse. An investigation of the incident will be initiated, if needed.

8. Misconduct involving the excessive or unacceptable use of force or intentional disregard of this policy will result in disciplinary action, up to and including dismissal.

9. For standardization purposes, the altering of any format to any Division policy attachment is prohibited, other than to complete the information required on the form itself.

10. Each facility will have in place an operational procedure to ensure the standards and practices of this policy are followed.

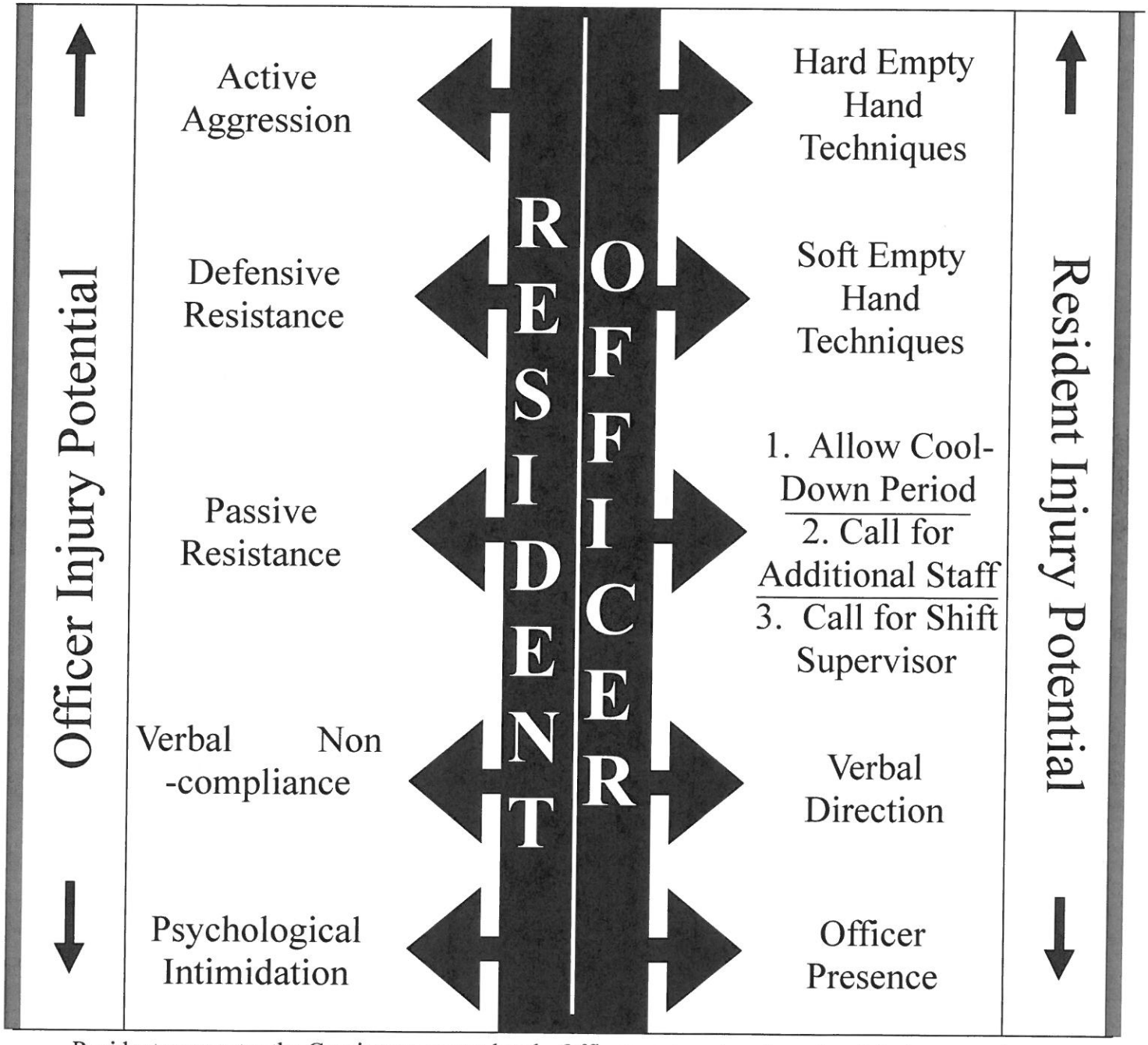
RIGHTS RESERVED

The Director reserves the right to modify, suspend or cancel any provision herein in part or entirety, without advanced notice, unless prohibited by law.

APPROVED: Stephanie Sund 7/1/17

Director **Date**

Resident Resistance - Staff Control Continuum



Resident may enter the Continuum at any level. Officers may enter at any level that represents a reasonable response to the perceived threat posed by the subject.

EMERGENCY RESTRAINT CHAIR AUTHORIZATION

(For use only if attached to the Passive and Mechanical Restraint Form and the ERC® is utilized during restraint)

Shift Supervisor Notified: ☐ Yes ☐ No

Medical Notified: ☐ Yes ☐ No

Type of restraints used prior to utilization of ERC®: _____

_____

Authorization Contacts

Position	Contact Time	Initial of Person Making Contact	Unable to Contact
Chief Correctional Officer			☐
Director of Security			☐
Facility Superintendent/Director			☐
Division ADO			☐
Mental Health Provider			☐
Division Supervising Psychologist			☐
DJS Director or Designee			☐

_____ _____

Shift Supervisor (Print) Signature of Shift Supervisor

ERC® Medical Authorization

According to our records, Resident _____, OIS # _____ has no pre-existing medical condition or injuries that could cause further medical complication or injuries if the ERC® is applied. Resident _____ can be placed in the Emergency Restraint Chair with continuous monitoring from the medical department and an ERC® certified staff member.

_____ _____

Medical Staff (Print) Signature of Medical Staff

_____ _____

ERC® Certified Staff (Print) Signature of ERC® Certified Staff

Shift Commander Videotape Briefing

The Team Commander will read the following:

Hello, my name is _____, I am the _____, today's date is _____, the time is _____, and our location is _____.

Support personnel present include: Medical _____, Treatment _____, and Support _____.

The reason we are here today, Resident _____ has continued to display behavior which could cause harm to himself or others. Resident _____ has also verbally assaulted and threatened staff. There have been multiple attempts to de-escalate the situation that include verbal counseling described herein: _____

_____

Resident _____ has also been given time out in order to deescalate and offer his/her solution to the current situation. Because all available options to control and deescalate the situation have been exhausted; the following team has been assembled:

Required Team Members

Camera Operator Name: _____. This staff person will be responsible for filming the room entry in its entirety. At no time will the camera stop recording. If for some reason the camera stops, the Shift Commander will be notified immediately. The camera operator will ensure they are filming from an angle that provides optimal coverage of the incident.

#1 – Point Name: _____. Responsibility will include making contact with resident and moving him/her to the nearest wall while controlling the upper torso and head. If shield is needed it will be carried by the *Point*. Once contact has been made and when appropriate, the *Point* will perform an inside take-down to place the resident on the floor.

#2 – High Right Name: _____. This member is responsible for controlling high right. Once the *Point* has made contact with the resident, the #2 position will peel off to the right and control the resident's arm. To gain control, the #2 position should pull the arm away from the body and in a downward motion to aid and assist the *Point* in placing the resident on the floor. The #2 position will at no time speak will performing his or her assignment.

#3 – High Left Name: _____. This member is responsible for controlling high left. Once the *Point* has made contact with the resident the #3 position will peel off to the left and control the resident's arm. To gain control the #3 position should pull the arm away from the body and in a downward motion to aid and assist the *Point* in placing the resident on the floor. The #3 position will be responsible for carrying and applying handcuffs. This team member will be responsible for announcing, "Resident Arms Secured".

Optional Team Members

(As deemed necessary as the Shift Commander deems it necessary to control the situation.)

#4 – Lower Right Name: _____. Will peel off to the right and when contact with resident has been made he/she will control the lower right side. Staff will attempt to control the resident's leg using an empty hand control technique. During this time #4 position will assist the *Point* with placing the resident on the floor.

#5 – Lower Left Name: _____. Will peel off to the left and when contact with resident has been made he/she will control the lower left side. Staff will attempt to control the resident's leg using an empty hand control technique. During this time #5 position will assist the *Point* with placing the resident on the floor.

Room Entry Debriefing

Hello, my name is _____ . The room entry on Resident _____ has been completed. Today's date is _____, time is _____. Resident _____ has been secured in room _____. Restraints ☐ **have** ☐ **have not** been removed at the time of this debriefing (see the Passive and Mechanical Restraint Form to ascertain when restraints were removed). Staff involved in the room entry (other than the Room Entry Team) include the following: ☐ No other staff involved

_____

_____

_____

All staff involved have been informed to provide written reports describing the incident in detail and questioned concerning the extent of any injuries that may have been sustained. ☐ No staff injury

Staff Member	**Team Position**	**Injury**	**Cause of Injury (if known)**

Resident _____ has been checked by medical. There were ☐ no injuries ☐ minor injuries ☐ extensive injuries. Injuries noted by Medical Staff _____

_____

_____

_____ _____

Medical Staff (Print Name) Signature of Medical Staff

_____ _____

Shift Commander (Print Name) Signature of Shift Commander